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Medicare Part D Update

January 2008

The Numbers

- 128,000 Medicare beneficiaries in SD
- Close to 70,000 South Dakotans enrolled in Part D
- 12,000 full benefit dual eligibles (FBDE)

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State's Role

- Education of beneficiaries and providers
- Staff trained to provide individual assistance with plan finder
  - Assistance to providers for enrollment
  - http://www.state.sd.us/social/MedicarePartD/ProvInfo/index.htm
- Liaison with federal government for certain issues

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Review of Specific Issues

- Co-pays
- Transition drug supplies
- Appeals
- Doughnut hole
- Possible future changes

Co-Pays

- FBDE, income 100%FPL or below, limited assets
  - No monthly premium or annual deductible
  - Co-payments of $1.05 for generics, $3.10 for brand name prescriptions
  - After co-payments reach $4050, no co-payment

Co-Pays

- Institutionalized FBDE
  - "Institutionalized" defined by Social Security Act (1902(q)(1)(B) and level of care defined at 42 CFR 435.1009
  - No monthly premium or annual deductible
  - No co-payment if institutionalized the calendar month or are in the institution with the expectation that they will be in the institution for the calendar month

Co-Pays

- Institutionalized FBDE
  - If approved for Medicaid in the month of entry and not in the facility on the first day of that month (partial month), beneficiary is responsible for co-pays in the month of entry
  - Co-pays in partial month can be reported to DSS benefit specialist for deduction from their income contribution toward cost of care

Co-Pays

- Assisted Living and HCBS Waiver FBDE
  - No monthly premium or annual deductible
  - Co-payments of $1.05/$2.25 for generics, $3.10/$5.60 for brand name prescriptions
  - Co-pays can be reported to DSS benefit specialist for deduction from their income contribution toward cost of care

Co-Pays

	Recipient A- Pre Part D	Recipient A- Post Part D
Current income	**$1,373.50**	**$1,373.50**
Deductions		
Maintenance needs allowance (includes $60 personal needs)	$623.00	$623.00
Medicare premium	$88.50	$88.50
Part D Co-payment	0	$19.00
Total Deductions	**$711.50**	**$730.50**
Recipient income available to facility	$662.00	$643.00

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Co-Pays

	Recipient A-Pre Part D	Recipient A-Post Part D
Monthly amount paid to facility		
Room and Board	$563.00	$563.00
Remaining recipient income	$662.00	$643.00
Amount paid by DSS	$238.86	$257.86
Total paid to facility	**$1,463.86**	**$1,463.86**

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Co-Pays

- FBDE and Medicare Savings Program (QMB, SLMB, QI) eligible with income 100%-135% FPL and limited resources
- No monthly premium or annual deductible
- Co-payments of $2.25 for generics, $5.60 for brand name prescriptions
- After co-payments reach $4050, no co-payment

Co-Pays

- Medicare only (not Medicaid eligible) with income below 150% FPL and limited resources
  - Premium based on sliding scale
  - Reduced deductible of $56 per year
  - 15% cost of prescriptions up to $4050 out of pocket maximum
  - Once maximum reached, $2.25 co-pay for generics and $5.60 for brand name prescriptions

Co-Pays

- **Caveat:**
- Premium is only $0 if person enrolls in a basic plan with premium at or below low income subsidy amount ($30.61)
  - Person responsible for difference in premium if they choose a more expensive plan
- Premium can be reported to DSS benefit specialist for deduction from their income contribution toward cost of care

Transition Drug Supplies

- At least one 30 day supply of the non-formulary drug during the first 90 days of enrollment in the plan
- If in a nursing facility, multiple 31 day supply of the non-formulary drug during the first 90 days of enrollment in the plan
- 2 options: switch drugs or request exception from plan

Navigating the appeal process

- Coverage determination must be requested
- Exception requests
  - Require physician statement, oral or written
  - Tiering exception
  - Formulary exception
- Can appeal unfavorable exception decisions
  - Five levels of appeal

Navigating the appeal process

- Level 1: *Redetermination* through the plan
- Level 2: *Reconsideration* by independent review entity
- Level 3: Administrative Law Judge hearing
  - $110 or greater
- Level 4: Medicare Appeals Council (MAC) review
- Level 5: Federal District Court review
  - $1090 or greater

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Navigating the appeal process

- Roles of members
  - Assumption that people can do this on their own or have someone to help
  - Use of appointed representative
    - CMS or equivalent form or be authorized rep, i.e., POA; use of LTC facility staff
- Role of physicians
  - Exception requests
- Role of pharmacies

Doughnut hole

- Does not apply to FBDE
- Begins once total drug costs reach $2510
- Recipients pay all drug costs until costs are $5726.25
  - Equivalent to $4050 out of pocket
- After drug costs reach $5726.25, plan pays 95% for remainder of year
- Some plans offer coverage in the doughnut hole

Possible future changes

- Simplification of processes, i.e. appeals, plan applications
- Market forces will likely result in fewer plans
  - Another transition process for those impacted
- Better customer service from plans
- Watch for changes in formularies and utilization controls

Discussion and Q&A

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